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Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent

Accepted: 8 June 1998

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Abstract Early cross-sex hormonal interventions (that is, between 16 and 18) as a treatment for young transsexuals are often considered to be risky. However, the delay of such treatment until after the development of secondary sex characteristics has obvious drawbacks for transsexual individuals. This paper reports a postoperative follow-up case-study of a female-to-male transsexual who was

treated with a combination of an LHRH agonist (which delayed her secondary sex characteristics development) and psychotherapy at age 13, and subsequently underwent sex reassignment at 18.

Key words Gender identity disorder – transsexualism – adolescence – sex reassignment – hormone treatment

Introduction

Sex reassignment for individuals with extreme gender identity disorder (GID) has long been restricted to adults. Prospective studies have shown that most GID children under 12 will not grow up to become transsexuals (5, 13, 14). Because of this, hormonal or any other medical intervention is never considered in prepubertal children. However, for some adolescents applying for sex reassignment, medical interventions may be a treatment option. Until recently, clinicians have been reluctant to start hormone treatment before the age of 18 or 21. It was felt that only in adulthood gender identity could be consolidated enough to allow for decisions regarding invasive interventions such as hormone and surgical therapy. Such a relatively late treatment start, however, has its drawbacks. Some individuals who have shown a pattern of extreme cross-sex identification from toddlerhood onwards may develop psychiatric disorders, e.g., depression, anorexia or social phobias, as a consequence of their hopelessness. Social and intellectual development may be adversely influenced. Also, the physical treatment outcome following interven-

tions in adulthood is far less satisfactory than when treatment is started at an age at which secondary sex characteristics have not yet been fully developed. This is obviously an enormous and life-long disadvantage. Ross and Need (11) found that postoperative psychopathology was primarily associated with factors that made it difficult for postoperative transsexuals to pass successfully as their new gender or that continued to remind them of their transsexualism. Furthermore, follow-up studies show that unfavorable postoperative outcome seems to be related to a late rather than an early start of the sex reassignment surgery (SRS) procedure (for reviews, see 6, 10). Age at time of assessment also emerged as a factor differentiating two groups of male-to-female transsexuals with and without postoperative regrets (7).

In some gender identity clinics a selected group of transsexual adolescents are now being treated hormonally before they are legal adults (age 18), but still after the age of 16. A careful diagnostic procedure includes more rigorous eligibility criteria than used for adults and a prolonged diagnostic procedure. The first follow-up study of adolescent transsexuals showed that 1–5 years after surgery the now young adults functioned socially and psychologically

satisfactory and that none had regrets in their decision. They functioned psychologically better than a group of transsexuals, who was treated in adulthood and evaluated with partly the same instruments (2). Despite these initial positive results, even younger adolescents (between 12 and 16 years) who wish to apply for sex reassignment have no other option than to wait for several years.

This paper reports a case of a female-to-male transsexual who attended the gender clinic at age 16. It appeared that she was already under treatment by pediatric endocrinologist with a luteinizing hormone-releasing hormone (LHRH) agonist, depot triptorelin, since the age of 13. This substance binds so strongly to the pituitary that endogenous LHRH can no longer exert its effects. The pituitary secretion of LH and FSH stops and the gonadal production of sex steroids stops therefore as well. As a result, when administered before puberty, puberty will not occur. Given after puberty, pubertal development will not proceed. The treatment does not appear to influence final adult height (4).

Case report

B came to the gender clinic requesting sex reassignment surgery at age 16. From interviews with her parents it appeared that she had always been a classical tomboy in her play activities and toy and peer preference and that she wished to be a boy from early on. Also, she showed boisterous and antagonistic behavior and was often in conflict with her father. At school she did well. At seven she had psychotherapy for a year, because of her oppositional and disobedient behavior, but without any success. When she was 12 her mother found a suicidal note, telling that she did not want to live any longer if she would enter puberty. Again she was treated by means of psychotherapy at the local mental health institute. Despite some improvement in her depressed mood her cross-sex behavior, interests, and identification remained. Her psychiatrist and a pediatric endocrinologist decided therefore to delay B's puberty by triptorelin treatment. By then she was 13 years old. Using this hormone she started to feel better about herself, thus, allowing her therapist to explore gender issues for an extended period, without being pressured by any physical developments.

When it appeared that B's gender identity would not change she ended her psychotherapy. However, being a transsexual was very shameful to her and she had great difficulties picturing herself to be one of 'them'. As the situation at home grew worse, her parents, who were not happy with the idea of sex reassignment, sought help again. They were referred to our gender clinic by their general practitioner. Cognitive testing revealed that B had

an IQ (WAIS) of 128 (verbal IQ: 133, performance IQ: 116; (12)). Personality assessment (the Dutch shortened MMPI (NVM) (8), the Dutch Personality Inventory (NPV), (9), Symptom Checklist-90 (SCL-90) (1), Rorschach (Comprehensive System, (3)) showed that she also had excellent problem-solving capabilities with respect to emotional matters. Vulnerable aspects of her psychological functioning were that she felt insecure about herself and moderately depressed, but no serious psychopathology was found: the majority of her questionnaire scores was in the average range, as compared to a large Dutch normative sample. Her shame concerning her transsexualism made her highly selective in her friendships and guarded in her contacts with new people. She felt close to her mother, but had many conflicts with her father. His Mediterranean background made acceptance of his daughter's masculinity very difficult. Following the regular clinical procedure (2) much time was spent exploring feelings of shame in individual sessions. A family therapist focused on conflicts between father and daughter, and father and mother. Occasional sessions with a small group of FM adolescents helped B in realizing that transsexuals can be just like other peers. When no psychological obstacles remained, cross-sex hormone treatment could start. However B chose to start at age 18, after she had graduated from high school.

Androgen treatment had a quick positive effect on B. At home she became more easy-going and friendly. After graduation from high school (age 18) she underwent a subcutaneous mastectomy (she had only developed a pseudogynaecomastia) and ovariectomy/uterus removal. Several months later she had her birth certificate changed.

In a follow-up interview one year after the ovariectomy and mastectomy, B reported no gender dysphoria at all. He said that he had found the adjustment to the male role to be very easy and expressed no doubts on the adequacy of his masculine behavior. He never felt any regrets about his decision and had never contemplated to live as a girl again. Knowing now what sex reassignment implied, he would do it all over again. B was happy with his life and did not feel lonely. He was currently studying to become a physician.

On the psychological questionnaires (the SCL-90, (1); the Dutch shortened MMPI, (8); and the Dutch Personality Questionnaire, (9)) he scored chiefly in the average range compared with scores of a normative Dutch sample. The only significant pre-post treatment change was a drop in his feelings of inadequacy. The majority of the other scores had slightly improved compared with the pretreatment situation. With regard to his social life, nobody had ever approached him as a woman after the development of secondary sex characteristics. B had not yet undergone metoidioplasty (i.e., transformation of the hypertrophic

clitoris into a micropenis) with a neoscrotum and implanted testes, but he intended to do so. He was therefore cautious in social activities such as sleeping over and showering after sports, but spent quite some time with close friends. As a result of his transsexualism he had not lost contact with family members or friends. B still did not easily engage in sexual encounters, because he disliked telling his partners about his physical incompleteness. Yet he was interested in sex and masturbated regularly. The frequency had increased since the start of his androgen treatment.

Most of his expectations on the physical changes had come true. Only his beard had grown much more slowly than he had expected; he also would have liked to be taller than he actually was. He looked and sounded, however, convincingly male.

B had found the time period between the start of treatment and the legal changes rather long but he was satisfied with other aspects of the sex reassignment procedure. He was very grateful that he had been given the opportunity to be treated this early.

When contacting B for approval of publication of his case, he wrote that he had undergone metoidioplasty and was very satisfied with the results.

Discussion

The case of B is the first we know of to show that pubertal delay and subsequent hormonal and surgical intervention

in a consistently cross-sex identified person has resulted in a positive outcome. In recent meetings of clinicians who treat adolescent transsexuals the minimum age of the start of hormonal treatment has been heavily discussed. Lowering this age might increase the incidence of 'false positives', but should also result in higher percentages of individuals who would more easily pass into the cross sex role than if treatment commenced well after the development of secondary characteristics. It may therefore result in a lower incidence of transsexuals with postoperative regrets. This holds especially for male-to-female transsexuals, because beard growth and voice breaking give so many of them a never disappearing masculine appearance. The most important advantage of pubertal delay over cross-sex hormone treatment is that no irreversible steps are taken. The therapist and transsexual can explore problems which possibly underlie the cross gender identity or clarify gender confusion under less time pressure. Although the physical side effects are few (4), this option also has its risks. Adolescents may consider this step a guarantee of sex reassignment, and it could make them therefore less rather than more inclined to engage in introspection. Furthermore, pubertal delay could widen the already existing social gap between transsexuals and their peers, which could increase the risk of pestering.

However, this case illustrates that pubertal delay as an additional tool in the diagnosis and treatment of young adolescents with GID should not be dismissed beforehand. For certain selected cases with a life-long consistent and extreme GID it may be a physical and psychological beneficial way to intervene.

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